

Medicare Part D Facilitated Enrollment Process

The Centers for Medicare and Medicaid Services (CMS) has taken steps to address the transition of dual eligible beneficiaries who present at a pharmacy after January 1, 2006 without being auto-enrolled into a plan offering Medicare prescription drug coverage. For instance, this could occur when an individual becomes newly qualified for Medicaid in-between the dates on which the State creates the monthly files for CMS. CMS has developed a point-of-sale solution, the “facilitated enrollment process”, to ensure full dual eligible individuals experience no coverage gap. Beneficiaries who present at a pharmacy with evidence of both Medicaid and Medicare eligibility, but without current enrollment in a Part D plan, may have a pharmacy claim submitted to a single account for payment. The beneficiary can have the prescription filled, the pharmacy claim would be paid, and a CMS contractor will immediately follow up to validate eligibility and facilitate enrollment into a Part D plan.

CMS has contracted with two vendors that will coordinate the facilitated enrollment process. **Wellpoint** (“POS Contractor”) is an approved national prescription drug plan (PDP) who will manage a single national account for payment of claims for dual eligible beneficiaries who have not yet been auto-enrolled into a Part D plan. Wellpoint will manage claims for all pharmacy providers regardless of their plan network or location. A basic plan will be offered for a premium at or below the regional low-income premium subsidy amount in every PDP region. Wellpoint will be able to both process the initial prescription (generally at in-network rates) and enroll the beneficiary in a matter of days, thus eliminating any gap in coverage. CMS’ second vendor is **Z-Tech** (“Enrollment Contractor”) can expedite validation of dual eligibility and return independently verified information on the individual’s eligibility for enrollment to the national PDP.

Since there is no fee-for-service component of Part D, the only way to process a claim at point-of-sale is through a Part D plan with an account set up to verify the beneficiary’s eligibility and accept the claim. The POS Contractor will maintain a pre-established service account to handle the initial processing of the claims, and will clear transactions from this account as soon as the Enrollment Contractor returns validated information. Claim transactions for verified dual eligible beneficiaries will be cleared by retroactively enrolling the dual eligible individual into the plan and reprocessing the initial claim with the correct member record. Claim transactions for individuals who are determined to be ineligible (no Medicaid and/or Medicare status) will be reversed to the pharmacy for collection.

This special facilitated enrollment would apply only to full-benefit dual eligible individuals, and not to the deemed (SLMB, QMB, QI-1) population, or Medicare-only beneficiaries

The process of facilitated enrollment will proceed as follows:

1. A full dual eligible beneficiary presents at the pharmacy with either a Medicaid card, or previous history of Medicaid billing in the pharmacy system patient profile.
2. Pharmacist bills Medicaid and the claim is denied.
3. Pharmacist requests photo identification and checks for Part D enrollment by submitting an E1 query to the TrOOP (True Out-of-Pocket) facilitator (**contact your software vendor or systems’ help line for instructions for submitting an E1 transaction**); pharmacist also checks for Medicare Part A and B eligibility by:
 - Requesting to see a Medicare card; or
 - Calling 1-800-MEDICARE; or
 - Requesting to see the Medicare Summary Notice (MSN)

The NDCHealth web site, http://medifacd.ndchealth.com/home/MediFacd_home.htm, provides more information on the TrOOP facilitation process.

4. If the E1 query returns Part D plan enrollment information, the pharmacist bills the appropriate plan.

**This process continues only if the pharmacist cannot identify
the appropriate plan to bill and the pharmacist is able to verify both
Medicaid eligibility (step 1) and Medicare eligibility (step 3).**

5. The Pharmacist enters the claim into the automated pharmacy system, including available data on the beneficiary such as name, ID number (HICN, Medicaid ID number, or SSN), date of birth, address, and phone number.
6. The Pharmacist submits the claim to the single pre-established service account indicated on the POS Contractors payer sheet, and in response to the paid claim, the prescription is filled, and the beneficiary pays at the \$1/\$3 cost sharing level.
7. The POS Contractor processes the claim as paid (network pharmacy) or as a captured response (out-of-network pharmacy). If the pharmacy is out-of-network then special instructions would be sent to the pharmacy to establish the mechanism for payment.
8. The POS Contractor sends a daily file to the Enrollment Contractor on the beneficiary data submitted with these paid claims.
9. The Enrollment Contractor uses this information to validate dual eligibility via access to CMS and state systems and returns validation of eligibility or ineligibility to the POS Contractor.
 - If dual eligibility is verified and the beneficiary has not been enrolled in a Part D plan, the POS Contractor would immediately submit an enrollment transaction on behalf of the dual to enroll him/her to a POS Contractor plan retroactively. Normal rules for duals opting out of the plan would apply.
 - If the beneficiary is a full dual and already enrolled in a Part D plan, the claim will be reversed and the pharmacy will bill the appropriate Part D plan.
 - If the beneficiary is Medicaid only, the claim will be reversed and the pharmacy will bill the appropriate state agency.
 - If the person claiming dual status is found to be Medicare eligible only, the Enrollment Contractor will notify the beneficiary by letter that s/he is ineligible for the facilitated enrollment service but may enroll in a Part D plan under normal enrollment rules, and the claim will be reversed to the pharmacy for collection.

Wellpoint will provide the details of this process on its industry “payer sheet” – the mechanism utilized in the pharmacy industry to communicate billing processes among pharmacies, switches and processors (payers). Payer sheets are collected by pharmacy IT staff and software vendors and systems are coded to automate as much as possible.

CMS is also producing a CD-ROM for distribution to pharmacists that will address these instructions, as well as use of the E1 (eligibility) query, coordination of benefits, and other issues of potential concern. This CD-ROM is targeted for completion early December. It will be distributed to CMS pharmacy contacts, and will be available upon request from CMS. Part D plans will be encouraged to advertise the CD-ROM or to make copies available to their network contacts.